IV INFUSION Treatment Center

FAX REFERRAL: **800-970-6020**

Intravenous Immunoglobulin (IVIG) Referral Checklist

Date: ___/___/___.

Referring Physician: _____.

Physician's Telephone #: _____ Facsimile #: _____.

Patient's Name: _____ Date of Birth: ___/___/___.

- ☐ Patient Demographics
- ☐ Most Recent Office Visit Note
- ☐ Laboratory (CBC, CMP, IgG with subclasses, IgA)

Diagnosis (Please check any which apply):

- ☐ Primary Humeral Immunodeficiency Syndromes - Dose 200 mg/kg-1000 mg/kg Q 3-4 weeks
  - ☐ Common Variable Immune Deficiency (D83-)
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (G61.81)

  Loading dose of 2000 mg/kg IV given in divided doses over 2—5 consecutive days. Maintenance infusion every 4 weeks: 200 – 500 mg/kg/dose

- ☐ Allow Physician/Pharmacist to initially/subsequently monitor serum immunoglobulin concentrations and dose IVIG

  - If left unchecked, clinical staff will automatically monitor and dose IVIG –

Comments/IVIG Brand Preference/Dosage Preference:

Office Staff Name: _____ Signature _____.